PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, May 29, 2001, at 10:00 a.m., Massachusetts Department of Public Health, Henry I. Bowditch Public Health Council Room, 2nd Floor, 250 Washington Street, Boston, MA. Present were: Dr. Howard K. Koh (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George Jr., Ms. Shane Kearney Masaschi, Mr. Albert Sherman, Ms. Janet Slemenda, and Dr. Thomas Sterne; Mr. Benjamin Rubin absent (one vacancy). Also in attendance was Ms. Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Susan Gershman, Director, Massachusetts Cancer Registry; Dr. Paul Dreyer, Director, Division of Health Care Quality; Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management; Ms. Louise Goyette, Director, Office of Emergency Medical Services; and Mr. Paul Jacobsen, Deputy Commissioner, Department of Public Health.

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETING OF JANUARY 23, 2001:

Records of the Public Health Council Meeting of January 23, 2001 were presented to the Council for approval. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the records of Public Health Council Meeting of January 23, 2001.

REQUEST FOR APPROVAL OF CHANGES TO THE LEMUEL SHATTUCK HOSPITAL BYLAWS 2001-2002 AS APPROVED BY THE HOSPITAL'S MEDICAL STAFF ON APRIL 5, 2001:

Changes to the Lemuel Shattuck Hospital ByLaws 2001-2002 as approved by the Hospital's medical staff on April 5, 2001 were presented to the Council for approval. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the Changes to the Lemuel Shattuck Hospital ByLaws 2001-2002 as approved by the Hospital's Medical staff on April 5, 2001.

PERSONNEL ACTIONS:

In a letter dated May 3, 2001, Katherine Domoto, M.D., MBA, Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the reappointments of the consultant and active medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted unanimously that, in accordance with the recommendation of the Associate Executive Director for Medicine at Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the provisional consultant and active medical staffs of Tewksbury Hospital be approved for a period of two years beginning May 1, 2001 to May 1, 2003:

REAPPOINTMENT:	**STATUS/SPECIALTY:**	**MEDICAL LIC. NO.:**
Murat Anamur, M.D.	Consultant/Hematology/ Oncology	72107
Michael Popik, M.D.	Consultant/Radiology	52454
Jesus Flores, M.D.	Active/Internal Medicine	41509

In a letter dated May 14, 2001, Mr. Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, recommended approval of the reappointments the allied, consultant and active medical staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted unanimously that, in

accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital,under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the medical staff of Lemuel Shattuck Hospital be approved:

REAPPOINTMENT:	**STATUS/SPECIALTY:**	**MED. LIC. NO.:**
Marianne Hughes, DMD	Consultant/Dentistry	18484
Anatha Kamath, MD	Consultant/Orthopedics	152230
Paul Marino, DMD	Consultant/Dentistry	9602
Barbara McGovern, MD	Active/Infectious Disease	74283
Joel Pearlman, DMD	Consultant/Dentistry	12623
Robin Reed, MD	Active/Internal Medicine	54662
S. Schwaitzberg, MD	Consultant/Surgery	55759
Benjamin Smith, MD	Active/Gastroenterology	76962
David Stone, MD	Active/Infectious Disease	54398

REAPPOINTMENT:	**STATUS/SPECIALTY:**	**MED. LIC. NO.:**
Margaret Ackerman, NP	AHP/Internal Medicine	143431

In a memorandum dated May 11, 2001, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Michael Botticelli to Program Manager VI (Staff Director, Commissioner's Office). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded , it was voted unanimously that in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Michael Botticelli to Program Manager VI (Staff Director, Commissioner's Office) be approved.

STAFF PRESENTATION:

"CANCER INCIDENCE AND MORTALITY FOR MASSACHUSETTS 1994-1998:STATEWIDE REPORT" WITH SPECIAL EMPHASIS ON MELANOMA, BY COMMISSIONER HOWARD K. KOH, M.D., M.P.H., AND SUSAN GERSHMAN, PH.D., DIRECTOR, MASSACHUSETTS CANCER REGISTRY:

Chairman Howard K. Koh, M.D., M.P.H. said in part, "The staff presentation today is a very important one on Cancer Incidence and Mortality for Massachusetts 1994-1998, with a special emphasis on melanoma. I want to dedicate this presentation to the memory of Congressman Joseph Moakley who, as you all know, succumbed, after his own courageous battle with cancer, yesterday. Congressman Moakley was a tremendous advocate for public health and I have many fond memories of working with him. In particular, there were several press conferences we had in this room with the Congressman on organ donation and also on many other areas of public health for which he was quite supportive. So we want to dedicate this presentation to him, and maybe I can ask for a moment of silence…"

Chairman Koh acknowledged the many people who made the report possible. Dr. Susan Gershman, Ph..D., Director, Massachusetts Cancer Registry, presented the statewide cancer incidence report. She began, "For the years 1994 to 1998, we had 152,148 diagnosed cases; 75,973 in males, 76,157 in females. As for the distribution of cancer, 64% is comprised of four cancers in males; prostate, almost a third of cancers, bronchus and lung, approximately 16%; colon and rectum, approximately 13%; and bladder at approximately 5%. For females, breast almost one third; bronchus and lung at about thirteen percent, colon and rectum about thirteen percent; and uterine about 6%. The distribution changes slightly for cancer deaths for males, about 58% of deaths for cancers; bronchus and lung at almost a third; prostate at about 11%; colon and rectum, eleven, and pancreas at about 5%. Pancreatic cancer is highly fatal. The five year survival is only about 4%. For females, once again, for cancers about 58% of the deaths; bronchus and lung actually surpassed breast back in 1987 as a leading cause of cancer deaths in women; breast at about 17%; colon/rectum about 12%, and pancreas about 6%…Now we are going to look at Massachusetts and what has happened over time. You can see between 1994 and 1998 in males

cancer has gone up slightly, about 3%. In females, it has increased about 7% and totally about 5%. We have a positive story for mortality. For males, cancer is down about 9%; for females, down about 7%; and totally, down approximately 8%…"

Dr. Gershman continued, "We are now going to look at specific cancers that have increased or decreased greater than 5%. Melanoma in males has gone up 28.8 % between 1994 and 1998. Bladder cancer has gone up about 10%, and prostate about 8%. For decreases, oral and pharynx has gone down about 5%….If we look at mortality, you can see for lung cancer it has gone down approximately 10%. Colon/rectum has also gone down about 10% and prostate has gone down about 18 percent. That is good news. We attribute the decrease in mortality to better screening, early detection, and we certainly have better treatment than we did eight or so years ago. Now we look at females. Once again, melanoma has risen about 14 percent. Lung is still rising in contrast to lung in males and this is because females started smoking later than males did. Breast is up slightly, and this is a national trend. We have decreases in oral and pharynx, about 8%; and cervix, about 19%, and actually we should have no cases of cervix in the registry. It is totally preventable. We have a great screening test and I certainly hope this decrease will continue over the coming years. Now we can see the increase in breast cancer. That again is approximately 9%; lung cancer about 10%; and colon/rectum in females is fairly stable. Mortality rates for lung cancer has gone up slightly, about 3%. Breast cancer is a pretty dramatic decrease at 19% and colon/rectum, down about 10%…In conclusion, prostate cancer rates have increased about 8% between 1994 and 1998 but there has been an overall decrease from its peak incidence in 1992. Breast cancer increased about 9%. Lung cancer has increased about 9%. Melanoma increasing 29 percent in males and about 19 percent in females, and leading cancers with increased incidence of at least 5% include prostate, melanoma and bladder in males; breast, lung and melanoma in females. Leading cancers with decreased incidence of at least 5% include oral cavity and pharynx in males and females and cervical in females. The Harvard Report on Cancer Prevention estimates the percent of total cancer deaths attributable to established risk factors. In the U.S., tobacco and adult diet/obesity, about 60%; all other factors, only 40%, and other factors include family history of cancer, viruses, and environmental pollution. At the Health Department, we have numerous cancer prevention and early detection programs: The Tobacco Control Program, Women's Health Network, Chronic Disease Prevention Program for Underserved Populations, Prostate Health

Awareness Programs, Skin Cancer Prevention Program and the Colo-Rectal Cancer Awareness Program."

Chairman Koh continued, "…We are turning the corner on the war on cancer. We are saving lives now, otherwise lost to cancer. I believe this reflects a tremendous statewide commitment to treatment, to education, and to prevention. It is also notable that, for our top four cancers: lung cancer, prostate cancer, breast and colorectal, mortality rates are dropping for all four of them, most notably in prostate, down some 17%, and breast cancer, down some 19% over that five year period. I am hoping that we will continue to see this progress as we move forward…"

Next, Chairman Koh discussed melanoma and skin cancer. He said in part, "…It is estimated that there are over a million new cases of skin cancer a year in the United States. The lifetime risk for skin cancer is one in four. We divide skin cancer into melanoma and non-melanoma skin cancer. Non-melanoma skin cancer generally does not metastasize and cause death; whereas, melanoma has a much higher potential of doing so…Melanoma incidence is rising faster than any other cancer. All skin cancer is caused by excessive sun exposure. Melanoma, in particular, seems to be caused by excessive harsh sun exposure. The blistering sunburn that you might get on that vacation. So, we urge sun protection and what we call safe sun to prevent all forms of skin cancer, melanoma and non-melanoma…The opportunity for melanoma skin cancer is a uniquely visual, external form of cancer. If you find melanoma early, it is curable. If you find melanoma too late, it can metastasize and cause death. Part of our public health efforts in the State and around the country is to promote early detection of melanoma…Our goal is to detect melanomas as early as possible. And the way that we do that is, we have been trying to teach medical students and the general public, since the mid –1980's, the A, B, C, D's of suspicious moles. So, if a mole is asymmetric, has an irregular border, has a darker, varied color, or diameter greater than six millimeters, which is a diameter of a pencil eraser, there should be a suspicion raised about whether the lesion, in fact, is not a normal mole, but melanoma. So, this is an area where not only health professionals, but the entire public can be involved, and we try to teach the A,B,C,D's of melanoma recognition to everybody because this should be a cancer that is totally curable, treatable, and preventable…Non-melanoma generally occurs on maximally sun-exposed parts of the body, the face and the hands. In contrast, melanoma can occur anywhere, but particularly affects covered parts of the body, particularly the back…No one

understands why melanoma occurs on non-maximally sun-exposed parts of the body. It may be that there is where the blistering sunburn is triggering the cycle of cancer initiation. As a clinician, I can tell you that many melanomas are found on the back areas of the body that a person cannot see well himself or herself. I often challenge my audiences, how many of you know right now which moles are on your back, which ones look fine, and which ones have the A,B,C,D qualities. Probably not too many of you could answer that. So, if you are a person at risk, a person with a family history, a person with a higher than average number of moles, a person who is Caucasian, lightly complected, burns easily, and tans poorly in the sun, not only do we talk about prevention and safe sun, but also early detection and being aware of what your moles look like all over your skin surface, particularly the areas that you may not be able to see well, like areas of the back."

"In the ideal world," Dr. Koh continued, "There would be no melanoma deaths…We can prevent melanoma though sun protection. We have to talk about educating people about A,B,C,D's. We have to stress the importance of early detection and possibly screening. We are promoting more and more the concept of safe sun, minimizing sun exposure during peak hours, seeking of shade, use of protective clothing and sunscreens, if necessary…We have been working closely with summer camps, to make sure that kids do not have excessive sun exposure. We have been working with Boards of Health around the state to promote safe sun, particularly in recreational sites, like on the water and around pools…We have conducted a number of epidemiologic investigations around the state concerning melanoma. We have mailed thousands of materials throughout the Commonwealth in various languages. Since this is a visible cancer, we want everybody to be able to recognize melanoma in its earliest form. We have worked with the Office of Child Care Services to promote sunscreens and other sun protection methods in child care centers and we even have a project in collaboration with Boston University, in birthing hospitals where new moms are talked to about promoting safe sun strategies right from the beginning of birth for their children. So this is a lifelong prevention activity. We are very excited at the work that the collaborative has done in a short period of time. We are concerned that melanoma incidence continues to rise faster than any other cancer. We want to continue to promote the power of prevention."

NO VOTE – INFORMATIONAL ONLY

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO THE HOSPITAL LICENSURE REGULATIONS REGARDING HOSPITAL EMERGENCY SERVICES DIVERSION STATUS SYSTEM – 105 CMR 130.000:

Dr. Paul Dreyer, Director, Division of Health Care Quality, presented an informational briefing on Proposed Amendments to the Hospital Licensure Regulations regarding Hospital Emergency Services Diversion Status System – 105 CMR 130.000. He said in part, "…I am here to present, for your information, a proposed amendment to the Hospital Licensure Regulations that will require hospitals to report their status vis-à-vis ambulance diversion via a worldwide web Internet-based system. Diversion has been much in the news lately. Diversion takes place when hospitals decide, for a number of reasons, that they can no longer accept 911 ambulance calls into their emergency departments. This is a nationwide phenomenon that is causing a great deal of discussion and concern, both in Massachusetts and elsewhere. This current regulation has to do with how ambulances notify the pre-hospital system when they go in diversion. Traditionally, hospitals have had to make numerous phone calls, send out faxes and otherwise communicate via what is essentially, from some points of view, obsolete technology, and so the message that a particular hospital is on diversion does not necessarily get to where it needs to get as quickly as it might. What we are proposing, which is currently being pilot tested, is a system whereby hospitals will simply update a data field on a web-based database, which will essentially change their status from off diversion to on diversion and vice versa, in real time. Any pre-hospital provider who has an appropriate password can simply look at the diversion, at the database and see, in real time, when hospitals go on diversion…The system is being pilot tested in EMS Region 2, and it is working quite well. Again, I want to stress, this is not going to solve the diversion problem. All it is going to do is enable hospitals to communicate more effectively with the pre-hospital community and it will also enable better coordination between hospitals and the pre-hospital community. We are proposing an amendment to the hospital licensure regulations that will require hospitals to report data to the system."

NO VOTE, INFORMATIONAL ONLY

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO THE EMERGENCY MEDICAL SERVICES SYSTEM REGULATIONS – 105 CMR 170.000:

Ms. Louise Goyette, Director, Office of Emergency Medical Services, presented an informational briefing on proposed amendments to the emergency medical services system regulations – 105 CMR 170.000. Ms. Goyette said in part, "…This is the companion piece requiring that ambulance services equip themselves with the ability to access information around hospital diversions via the web-based system. We tried to use the existing resources that are out there, and they are not one hundred percent available in every single ambulance in the state, but we did try to maximize and optimize existing resources so as not to create, or at least to minimize some of the financial affects that ambulance services could have. There are three ways that the regulations would allow ambulance services to access the system directly…Through the ambulance service or in individual ambulances, ambulance vehicles that are internet-based equipped. Surprisingly, there are more and more of those technologies available out there. Secondly, they can equip their dispatching center. However, it may be that the dispatching entity for a municipal ambulance service is the primary answering point for 911, otherwise known as the P-SAP. The other option would be for the ambulance services dispatch entity to access the web site either through a CMET Center or through some other dispatching center. The smaller, volunteer-type communities have a number of options and we feel that most of them will not have to make any substantial monetary investment to access the system. This kind of information for ambulances on the road, with patients in them, real time, is absolutely essential because it minimizes the risk of an ambulance literally heading in the wrong direction to get a patient into an open emergency department. We felt that this was pretty important to try to get this system which we actually utilized this past winter to monitor Region 2 diversion, particularly on weekends where we had storms and whatnot, during off hours. It worked extremely well, and we were extremely happy with it. It is time to go statewide. We would like to have this in place prior to next winter's flu season, which is why we are targeting October 1, 2001."

NO VOTE, INFORMATIONAL ONLY

REGULATION:

REQUEST FOR EMERGENCY ADOPTION OF CRIMINAL OFFENDER RECORD CHECKS REGULATIONS – 105 CMR 950.000:

Mr. Paul Jacobsen, Deputy Commissioner, said in part, "…On November 21, 2000 and subsequently on February 27, 2001, the Public Health Council approved a request to adopt regulations on an emergency basis entitled Criminal Offender Record Checks (105 CMR 950.000). Since emergency regulations are only effective for 90 days, the regulations are due to expire on May 29, 2001. The purpose of the regulations is to establish standardized procedures for the Department of Public Health and its contracted vendors with respect to the review of criminal records of candidates for employment or regular volunteer or training positions. The regulations require the Department and programs funded by the Department to request criminal offender record information (CORI) for every candidate, and to review that information to determine if the individual is appropriate to be hired under the guidelines set out in the regulations. The Department held a public hearing on January 19, 2001 for the purpose of receiving comment on the regulations. More than 60 people testified at that time, and the Department received more than 120 written comments. Given the number of comments and broad scope of the testimony, Department staff are still in the process of analyzing the issues raised by the testimony. Since these regulations are part of a secretariat-wide initiative, Department staff are working with representatives from the Executive Office of Health and Human Services and other human service agencies to discuss possible revisions to the regulations. Staff expects to complete its review and to propose amended regulations by the June 26th meeting of the Public Health Council. In the meantime, since the initial emergency regulations are due to expire, the Public Health Council is requested to adopt the emergency regulations again to ensure that the requirements of the regulations continue to be met."

Mr. Jacobsen continued, "The regulations establish four categories of criminal offenses that might show up on a CORI check: mandatory disqualification, ten year presumptive disqualification, five year presumptive disqualification and discretionary disqualification. In the event that a candidate for employment or a volunteer or trainee position has a mandatory disqualification, that candidate will be ineligible for any position that involves potential unsupervised contact with a client of a program operated

or funded by the Department. Candidates with a 5 or 10 year presumptive disqualification may be eligible for positions involving potential unsupervised contact with clients, but only after the 5 or 10 year period has passed or the candidate's probation officer, parole officer or other criminal justice official, or forensic psychiatrist or psychologist concludes in writing that the candidate is appropriate for the position and the employer conducts a review to determine that the candidate does not pose a danger to clients. An individual with a discretionary disqualification may be eligible for a position involving potential unsupervised client contact only after the employer conducts a review to determine that the candidate does not pose a danger to clients. The Public Health Council is requested to adopt these regulations on an emergency basis so that they will remain in effect until such time as the Council approves a revised, final version of the regulations at the June 26th meeting. The Department regards this matter as a priority to protect clients receiving services in programs funded or operated by the Department. All EOHHS agencies have adopted comparable regulations on an emergency basis or as final regulations, which are intended to replace guidelines issued by EOHHS in 1996. Renewing the regulations on an emergency basis ensures that the requirements will continue to apply to all programs funded or operated by the Department."

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve the Request for Emergency Adoption of Criminal Offender Record Checks Regulations –105 CMR 950.000**; that a copy of the emergency regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the emergency regulations be attached to and made a part of this record as **Exhibit Number 14,712**. .

The meeting adjourned at 10:50 a.m.

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Howard K. Koh, M.D., Chairman
Public Health Council

LMH/SB